The Federal Affordable Care Act

(Summary of Major Insurance Provisions and Implementation in Wisconsin)

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The federal Patient Protection and Affordable Care Act, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, enacted on March 31, 2010, made comprehensive changes to the private health insurance market and to publicly funded health care programs in the United States. Together, these acts are commonly referred to as the Affordable Care Act (ACA).

The ACA is intended to reduce the number of U.S. citizens who lack health care coverage, primarily by: (a) making private health care coverage more affordable through insurance market reforms and by providing subsidies to qualifying individuals and families that purchase private health care policies on the new health benefit exchanges (Marketplaces); (b) providing opportunities and fiscal incentives for states to provide health care coverage to additional individuals under their medical assistance (MA) and children's health insurance programs (CHIP); (c) requiring most individuals to maintain healthcare coverage or be subject to financial penalties; (d) creating financial penalties for certain employers that fail to provide their employees affordable coverage that meets minimum coverage requirements; and (e) offering federal tax credits to small businesses that purchase health insurance coverage for their workers through the small business health options program (SHOP).

In April, 2014, the Congressional Budget Office (CBO) estimated that, as a result of the ACA, the number of nonelderly individuals in the United States who lack coverage would decrease from approximately 54 million to 42 million in 2014. The projected 12 million decrease in uninsured individuals would occur due to: (a) projected increases in the number of individuals who would purchase qualified insurance through state Marketplaces (6 million), and who would obtain coverage by enrolling in MA and CHIP (7 million), and a reduction in the number of citizens who have coverage from nongroup policies and other sources (-1 million). CBO estimated that the number of uninsured, nonelderly citizens would continue to decrease to approximate 30 million by 2016, as more individuals and families would purchase plans through the Marketplace and enroll in MA and CHIP.

This paper summarizes the major provisions of the ACA that affect private health insurance coverage available to Wisconsin residents, and provides information on 2014 enrollment in plans available through Wisconsin's federally-facilitated Marketplace. It also summarizes changes to the state's BadgerCare Plus eligibility standards that took effect on April 1, 2014, in response to the enactment of the ACA.

ACA Insurance Reforms

This section summarizes several of the most significant provisions enacted in the ACA that relate to the private health insurance market. Most of these provisions are codified in Title 27 of the Public Health Service Act ("Requirements Relating to Health Insurance Coverage"). To the extent that current state law would prevent the application of a provision of the ACA (for instance, where state law allows for certain pre-existing condition exclusions), federal law supersedes state statutes.

In some cases, these provisions apply differently for plans purchased in the individual market (where individual or family purchases coverage from an insurer) and in the small group market (where employers with up to 50 employees, and, beginning in 2016, employers with up to 100 employees, purchase a single plan that provides coverage for all of their employees). In addition, some "grandfathered" and "transitional" health plans are exempt from some of the ACA requirements.

Preexisting Condition Exclusions. The ACA prohibits plans from imposing any preexisting condition exclusions. A preexisting condition exclusion is a limitation of benefits relating to a medical condition that existed before an individual's date of enrollment for coverage. The provision took effect for children under 19 years of age on September 23, 2010, and for adults on January 1, 2014.

Guaranteed Issue and Renewal. Under the ACA, health plans must sell health insurance policies to anyone who applies for the coverage, regardless of the health status of the individual, age, gender, or other factors. Health plans must also renew, or continue in force, coverage at the option of the employer or individual. Individual plans may restrict enrollment to certain open enrollment periods, while an employer can purchase a group health plan any time during the year. Under limited circumstances, a plan may be exempt from the guaranteed issue requirement, such as if the plan does not have an adequate network capacity to serve additional enrollees. This requirement applies to all plans created after March 23, 2010, for plan years beginning on or after January 1, 2014.

Premium Rate Restrictions. Beginning January 1, 2014, insurers must establish premiums for individual and small group plans that vary only by the following factors: (a) whether the coverage is provided for an individual or a family; (b) geographic rating areas (regions designated by each state that insurers must uniformly use as part of their rate-setting); (c) age, with rates not varying by a ratio of more than three to one for adults; (d) tobacco use, with the rates not varying by a ratio of more than 1.5 to one. Consistent with prior federal law, group plans may offer incentives based on enrollee participation in wellness programs to reduce the cost of the enrollee's coverage.

Medical Loss Ratios. The ACA requires health plans to annually report to the U.S. Department of Health and Human Services (DHHS) the percentage of premium revenue the plan collected that was spent on medical claims (the plan's medical loss ratio, or MLR). Plans in the individual and small group market must meet a minimum MLR of 80%; plans in the large group market must meet a minimum MLR of 85%. Health plans that do not meet those standards must provide rebates to policyholders. These requirements first took effect in 2011. For plan year 2013, four insurers selling polices in the individual market in Wisconsin owed premium refunds of $2,585,000 to a total of 69,396 consumers. All insurers in the small and large group markets met the MLR standards.

Prohibition on Policy Rescissions. The ACA prohibits the retroactive cancellation of group or individual coverage (the "rescission" of the policy) once an individual is enrolled in that plan or coverage, except in situations where an individual performs fraud or intentional misrepresentation. This provision first applied to coverage beginning September 23, 2010.

Limit on Waiting Periods. The ACA prohibits group health plans from establishing a "waiting period" that exceeds 90 days. A waiting period is the time between an individual's eligibility determination and when the policy's coverage begins. By rule, this provision applies to group health plans for plan years beginning on or after January 1, 2015, although the ACA's initial applicability date for this provision is January 1, 2014.

Coverage of Dependents under Age 26. The ACA requires group or individual coverage that

provides coverage of dependent children to make that coverage available for any adult child under the age of 26, including adult children who are not enrolled in school, adult children who are not listed as dependents on their parents' tax returns, and those who are married. This requirement applied to coverage for plan years beginning on or after September 23, 2010.

Prior provisions in state law that extended dependent coverage to dependents up to the age of 27 only applied to fully-insured employer-based coverage (where an employer purchases a policy from an insurer) and individual insurance policies. However, self-funded private employer plans (where the employer pays for health benefits from its own funds) are not subject to state mandates. The ACA dependent coverage provision applies to all private employer-based coverage, regardless of the type of coverage arrangement an employer chooses.

Annual and Lifetime Benefit Limits. Under the ACA, no plans and policy issued or renewed after September 23, 2010, may include a lifetime limit on the dollar value of benefits available to the policyholder. In addition, the ACA phased out annual limits included in plans and policies (other than grandfathered plans), beginning for plan and policy years starting on or after September 23, 2010. By January 1, 2014, none of these plans or policies may include annual limits on the dollar value of benefits.

Coverage of Preventive Services. The ACA requires group health plans to provide coverage for certain preventive services without any cost-sharing requirements (such as deductibles, coinsurance, or copayments). These preventive services include the following: (a) certain evidence-based services recommended by the U.S. Preventive Services Task Force; (b) immunizations recommended by the Centers for Disease Control and Prevention; (c) care and screenings for infants, children, and adolescents in guidelines supported by the Health Resources and Service Administration (HRSA); and (d) additional preventive care and screenings for women not described above, as provided in the HRSA guidelines. These provisions became effective on September 23, 2010.

Wisconsin's statutes contain several mandates that require private insurance policies provide certain services, including certain preventive services. However, the state's insurance mandates for preventive services do not apply to self-funded private employer plans, while the ACA provision applies to all employer plans. State mandates remain in place, and continue to apply to all plans other than self-funded plans.

Grandfathered Employer-Based and Individual Health Plans. The ACA defines "grandfathered health plans" as health plans in effect on the date of the law's enactment, and initially exempts these plans from some of the provisions of the act. However, all grandfathered plans are required to comply with the prohibition on lifetime limits on benefits, the prohibition on rescissions, required coverage of dependent children up to age 26, and MLR requirements.

Prohibition on Discrimination Based on Salaries. The ACA includes provisions that are intended to prevent employer-sponsored group health plans from discriminating in favor or highly-compensated employees, either with respect to eligibility for the plan or benefits offered under the plan. Current federal rules that prohibit discrimination currently apply to self-funded plans, but not group health plans. To date, the Internal Revenue Service (IRS) has not promulgated rules to implement this provision, and has indicated that it will not enforce the ACA provision until rules are in effect.

High-Risk Pool Funding. The ACA created the pre-existing condition insurance plan (PCIP) to provide access to health insurance coverage to individuals with pre-existing medical conditions and who had been without creditable coverage for at least six months prior to application. The

program was intended to provide immediate access to healthcare coverage for individuals with pre-existing conditions until the ACA's provisions prohibiting pre-existing conditions took effect in 2014. States were provided the option to operate their own PCIP, supported with one-time federal funds authorized under the ACA, or permit the federal Department of Health and Human Services (DHHS) to operate the plan.

In May, 2010, the state's Health Insurance Risk-Sharing Plan (HIRSP) Authority was designated as the administrator of the plan in Wisconsin, and began offering four federally-funded plans, each with different deductibles and out-of-pocket maximum limits. On February 28, 2014, the HIRSP Board of Directors became an advisory council to the Office of the Commissioner of Insurance, which assumed responsibility for the close-out of all plans administered by HIRSP. On April 1, 2014, all PCIP plans offered by HIRSP ended.

Individual and Employer Mandates

The ACA requires most individuals to maintain health coverage or pay a penalty, a provision commonly referred to as the "individual mandate." The law also imposes penalties on certain employers whose employees receive federal tax credits to purchase coverage, commonly referred to as the "employer mandate." This section describes each of these mandates.

Individual Mandate. The ACA generally requires individuals to obtain "minimal essential coverage," which includes all of the following: (a) any government-sponsored program, such as Medicare or Medicaid; (b) coverage under an eligible employer-sponsored plan; (c) plans offered in the individual insurance market; (c) grandfathered health plans; or (d) other health plans, recognized by the DHHS Secretary in coordination with the Secretary of the Treasury. Minimum essential coverage does not include plans with a limited scope of benefits (such as dental), plans where health care benefits are secondary (such as workers' compensation plans), plans that only cover a specified condition, and Medicare supplemental insurance plans.

Beginning January 1, 2014, the ACA requires "applicable individuals" to maintain minimum essential health insurance coverage. The law defines an applicable individual as any individual other than the following: (a) an individual granted an exemption based on religious beliefs; (b) an individual that is not a U.S. citizen, or an alien lawfully present in the U.S.; or (c) an individual that is incarcerated, other than incarceration pending the disposition of charges.

Applicable individuals who do not maintain minimum essential coverage for a period of three or more continuous months in a year may be assessed a penalty ("shared responsibility payment") for each month an individual is without coverage. The annualized penalty amount equals the greater of the following: (a) $695 per adult, and $347.50 per child, up to a maximum of $2,085 per family; or (b) 2.5 percent of the amount by which an individual's gross household income exceeds that year's filing threshold (in 2014, $10,000 for individuals and $20,000 for married couples under the age of 65). An adult who can claim a child or another individual as a dependent for federal income tax purposes is responsible for making the payment if the dependent does not have coverage or an exemption.

This penalty phases in over three years, according to the following schedule:

Calendar Year	Flat Fee Per Adult	% of Income
2014	$95	1.0%
2015	325	2.0
2016	695	2.5

Beginning in 2017, the flat fee penalty will be indexed to the consumer price index. All penalties assessed are payable through an individual's annual tax return. If a taxpayer fails to pay a penalty, the IRS will notify the taxpayer and may attempt to collect the amount owed by reducing the amount of their tax refund for that year or future years. Failure to pay the individual mandate penalty is not grounds for criminal prosecution or additional penalties.

The ACA caps the penalty for noncompliance at the national average premium for bronze-level health plans offered through exchanges, adjusted to reflect family size. (The designation of plans by "metal tiers" is discussed later in this paper.) For 2014, this average premium is $2,448 per individual per year. If a taxpayer is required to pay a penalty for more than one individual, the monthly amount is multiplied by the number of individuals subject to a penalty.

Certain applicable individuals are not subject to penalties if they lack minimum essential coverage, including the following: (a) an individual whose required contribution for coverage is unaffordable (the contribution exceeds 8% of that individual's household income); (b) an individual with household income below the filing threshold; (c) a member of an Indian tribe; or (d) any applicable individual who the DHHS Secretary determines has suffered a hardship with respect to the capability to obtain coverage for any month. Other exemptions are specified by rule, such as an exemption for individuals who are not eligible for MA solely as a result of a state's decision not to provide MA coverage for adults in families with income up to 133% of the FPL, and other specified situations.

In June, 2013, the DHHS Centers for Medicare and Medicaid Services (CMS) provided more specific guidance to Marketplaces with respect to granting hardship exemptions. These hardship exemptions apply to multiple specific situations, including when an individual becomes homeless, has received a shut-off notice from a utility company, or recently experienced domestic violence. Individuals are allowed an exemption if the period without insurance coverage does not exceed one three-month period in any given calendar year.

Individuals may claim certain types of exemptions by requesting certification through the Marketplace (such as an exemption for religious reasons), by either requesting certification through the Marketplace or through a tax filing (such as a hardship exemption), or exclusively through a tax filing (such as an affordability exemption).

The constitutionality of the individual mandate was one subject of the U.S. Supreme Court decision in *National Federation of Independent Business et al v. Sebelius*. The Court ruled that the mandate was a legitimate use of Congress's taxing power.

Employer Mandate. The ACA authorizes the IRS to assess penalties ("employer shared responsibility payments") to certain employers that fail to offer their full-time employees affordable minimum essential coverage, and if any full-time employee receives a premium tax credit for exchange-based coverage. Under the ACA, these provisions were scheduled to take effect beginning January 1, 2014. However, on July 9, 2013, the IRS issued a notice indicating that no such penalties would be assessed for 2014.

On February 10, 2014, the IRS issued final regulations relating to employer shared responsibility payments. An employer that had an average of 50 full-time employees (or an equivalent combination of full-time and part-time employees) in the preceding calendar year is an "applicable employer." For this purpose, the ACA defines full-time employees as employees that work 30 or more hours per week.

An employer must make a shared responsibility payment to the IRS if any full-time employee receives a premium tax credit or cost-sharing reduction through an exchange, regardless of wheth-

er the employer offers minimum essential coverage. In general, an employer may be subject to a penalty if the employer offers health care coverage that does not meet the federally-defined affordability test (the employee's required contribution for self-only coverage does not exceed 9.5% of the taxpayer's household income) or minimum value requirements (an actuarial value of at least 60%).

Employers that do not offer coverage to their employees and have at least one full-time employee who receives a premium tax credit must pay an annual penalty of $2,000 per full-time employee. The employer's first 30 employees are excluded from the assessment. For an employer that offers coverage in some months but not others during the calendar year, a prorated penalty is calculated separately for each month for which coverage was not offered.

Employers that offer coverage but have at least one full-time employee who receives a premium tax credit must pay a penalty equal to $3,000 annually for each full-time employee that received a tax credit. A prorated monthly penalty is charged based on the number of employees receiving tax credits in a given month. An employer who offers coverage can never be penalized an amount that exceeds the amount that the employer would owe if it did not offer coverage.

Appendix 1 provides several examples of how the employer shared responsibility payments would be calculated.

Qualified Health Plans and Essential Health Benefits

The ACA establishes standards for qualified health plans (QHPs), including cost-sharing and maximum benefit standards, and a set of benefits the plans must cover (the essential health benefits, or EHB). All policies sold on the exchange and in the individual market outside the exchange must meet these QHP standards.

The ACA defines a QHP as a health plan certified to meet standards established by the DHHS Secretary, which includes minimum criteria specified in the ACA. A health insurance issuer that offers a QHP must offer at least one plan in the silver level and gold level in the Marketplace, and charge the same premium rate on and off the exchange for the same QHP.

Out-of-Pocket Limits and Cost-Sharing. The ACA defines four "metal tiers" for plans that differ in terms of the actuarial value of the benefits provided under the plan. The actuarial value represents the average value of the benefits covered by plan over an average population. In other words, the plan with a 60% actuarial value will pay roughly 60% of the health care costs for everyone covered by the plan. The ACA defines the following coverage tiers: (a) bronze, which covers 60 percent of the full actuarial value of the benefits under the plan; (b) silver, which covers 70 percent; (c) gold, which covers 80 percent; and (d) platinum, which covers 90 percent. In general, plans with high actuarial values charge higher premiums, but have lower cost-sharing requirements than plans with lower actuarial values.

The ACA limits the maximum annual out-of-pocket amount that an enrollee could pay in cost-sharing requirements for covered benefits in a QHP to no more than the limits that apply to plans that qualify the enrollee to open a health savings account. In 2014, these limits were $6,350 for an individual plan and $12,700 for a family plan.

Essential Health Benefits. The ACA directs the DHHS Secretary to define the benefits that a QHP must offer, and requires that the plan must include at least the following general categories: (a) ambulatory patient services; (b) emergency services; (c) hospitalization; (d) maternity and newborn care; (e) mental health and substance use disorder ser-

vices, including behavioral health treatment; (f) prescription drugs; (g) rehabilitative and habilitative services and devices; (h) laboratory services; (i) preventive and wellness services and chronic disease management; and (j) pediatric services, including oral and vision care. In addition, the ACA requires the DHHS Secretary to ensure that the scope of the EHB is equal to the scope of benefits provided under a typical employer plan.

DHHS rules directed each state to identify a single EHB "benchmark plan" from among several options: (a) the largest health plan by enrollment in any of the state's three largest small group insurance products; (b) any of the largest three employee health benefit plan options by enrollment offered to state employees; (c) any of the largest three national federal employees health benefit program plan options by enrollment; or (d) the plan with the largest commercial non-MA enrollment offered by a health maintenance organization in the state. If a state does not choose one of these benchmarks, the default benchmark plan for the state is the largest small group plan described under (a).

Wisconsin did not select an EHB benchmark plan in 2014. The default plan, Choice Plus Definity HSA Plan, offered by UnitedHealthcare Insurance Company, served as Wisconsin's EHB benchmark plan in 2014 and will serve as Wisconsin's EHB benchmark plan in 2015. A summary of the covered benefits and limitations of that plan is available on the OCI website at: oci.wi.gov/ healthcare ref/ehb_wi-benchmark-plan.pdf

Under the ACA, if a state chooses to establish a new insurance mandate, the state is required to fund the additional cost for the mandated benefit to individuals who purchase qualified plans in the Marketplace. The method that will be used to calculate and pay these additional costs has not yet been determined.

Catastrophic Plans. The ACA permits insurers to sell "catastrophic plans" to individuals under 30 years of age, and to individuals who are exempt from the individual mandate. These plans must provide the essential health benefits package only after the satisfaction of the maximum out-of-pocket cost-sharing amounts (in 2014, $6,350 for an individual plan and $12,700 for a family plan) and coverage for at least three primary care visits. Qualifying individuals may purchase catastrophic plans to comply with the individual mandate.

Health Benefits Exchanges

The ACA created health benefit exchanges (Marketplaces), through which consumers can obtain information and purchase coverage in QHPs. In addition, federal tax credits to help purchase coverage are generally only available to individuals who purchase plans offered through the Marketplaces. This section discusses the establishment of Marketplaces by states and the federal government, and the premium and cost-sharing assistance available through them.

Establishment of Marketplaces. The ACA requires each state, no later than January 1, 2014, to establish a Marketplace to facilitate the purchase of QHPs. Each Marketplace must also provide for the establishment of a small business health options program (SHOP) to assist employers in enrolling their employees in QHPs offered in the small group market. If a state does not establish its own Marketplace, the ACA directs DHHS to establish and operate the state's Marketplace.

The ACA requires the Marketplace, at a minimum, to undertake all of the following: (a) certify health plans as QHPs; (b) operate a toll-free telephone hotline; (c) maintain a website for the comparison of qualified health plans; (d) assign a rating to each qualified health plan offered through the Marketplace; (e) use a standardized format for presenting health benefits plan options; (f) inform individuals about eligibility for public programs

such as Medicaid, and enroll eligible individuals in those programs; (g) determine the cost of coverage after applying premium tax credits, or cost-sharing reductions; (h) certify that an individual is exempt from the individual mandate due to a lack of an affordable coverage option, or other exemption; (i) transfer to the U.S. Department of Treasury and to employers certain information regarding individuals who participate in the Marketplace; and (j) establish the "navigator" program, where entities receive grants to conduct educational and enrollment activities.

In 2014, 16 states and the District of Columbia established their own state-based Marketplaces. Twenty-one states, including Wisconsin, chose not to establish an exchange, and DHHS performed the functions relating to the state's exchange ("federally-facilitated Marketplaces"). Thirteen states chose to divide Marketplace functions between DHHS and the state ("Partnership Marketplaces"). For the 2014 plan year, 13 insurers offered plans on Wisconsin's federally-facilitated Marketplace. Twelve of these insurers, along and five other insurers, sold plans outside of the Marketplace.

Open enrollment for 2014 plans available in all states' Marketplaces began on October 1, 2013, and ended on March 31, 2014. Some individuals may enroll in a plan after the open enrollment period ends because they qualify for a special enrollment period due to several types of qualifying events. Examples of these qualifying events include a marriage or divorce, the birth or adoption of a child, a change in residency, or losing other health coverage due to the loss of a job or losing eligibility for MA. Any plan in which an individual enrolls during a special enrollment period terminates on December 31 of the plan year. For coverage starting in 2015, the open enrollment period is November 15, 2014, through February 15, 2015.

Appendix 2 provides information on enrollment in Wisconsin's federally-facilitated Marketplace during the first open enrollment period, as compiled by the DHHS Office of the Assistant Secretary for Planning and Evaluation, as of May 1, 2014.

Appendix 3 provides information on the type of exchange that operated in each state in 2014. The appendix also indicates the following information for the first open enrollment period: (a) the number of individuals determined eligible to enroll in a Marketplace plan, including those eligible for federally-funded financial assistance; (b) the number of individuals who selected a Marketplace plan; and (c) the number of individuals determined eligible by the Marketplace for coverage under the state's MA or children's health insurance program.

In recognition of difficulties the federally-facilitated and state-based Marketplaces had in providing timely eligibility determinations during the first year of operations, CMS issued policy guidance in February, 2014, that offered retroactive advance payments of the premium tax credits and cost-sharing subsidies for the 2014 coverage year, for certain individuals enrolled in QHPs offered outside of the Marketplace.

Premium Tax Credits and Cost-Sharing Subsidies

Premium Assistance Tax Credits. Individuals and families may qualify for tax credits to help pay for health insurance premiums if they meet all of the following criteria: (a) purchase coverage through the Marketplace; (b) have household income between 100% and 400% of the federal poverty level (FPL); (c) may not obtain "affordable coverage" through an eligible employer plan that meets "minimum value" requirements (premiums for self-only coverage of no more than 9.5% of household income, and actuarial value of at least 60%); (d) do not qualify for coverage through a government program; (e) if married, file a joint tax return (with limited exceptions); and (f)

cannot be claimed as a dependent by another person.

In 2015, the premium tax credits, which are established and administered by the IRS, cap the amount the individual is expected to contribute for premiums, based on the individual's household income, according to the schedule shown in the table below. As the percentages are adjusted annually, the 2015 percentages are slightly higher than the percentages that applied in calendar year 2014.

Percent of FPL	Percentage of Income Expected to Pay for Premium*
Up to 133%	2.01%
133% to 150%	3.02 % to 4.02 %
150% to 200%	4.02 % to 6.34 %
200% to 250%	6.34 % to 8.10 %
250% to 300%	8.10 % to 9.56%
300% to 400%	9.56%

*Percentage increases within this range as income increases.

Although an enrollee can receive a tax credit for the purchase of a plan of any "metal tier," the premium tax credit amount that a household receives is based on the cost of second-lowest cost silver plan available. For that reason, individuals may pay less in premiums than the specified percentage of their income if they apply the tax credit to the purchase of a less-expensive policy (for instance, a bronze plan), or may pay more than the specified percentage if they apply the tax credit to a more-expensive plan (such as a gold or platinum plan).

Based on information an individual provides at the time of application for coverage, the Marketplace estimates the amount of the premium tax credit that the individual may claim. The applicant must then determine what portion of the estimated tax credit should be paid in advance directly to the insurance company to reduce monthly premium payments. Enrollees who choose to have all or some of their tax credit paid in advance are required to reconcile, on the following year's federal income tax forms, the amount of these payments with amounts that can be claimed based on the actual household income and family size.

Appendix 4 shows the 2014 federal poverty levels, and examples of calculations of the monthly premiums that low- and moderate-income families were expected to pay for second-lowest cost silver plan in 2014 after the application of the premium tax credits.

Cost-Sharing Reductions. Individuals in families with income between 100% and 250% of the FPL may be eligible for cost-sharing subsidies. For these purposes, "cost-sharing" refers to copayments, coinsurance, and deductibles. To qualify for these subsidies, an individual must enroll in a QHP with the "silver level" of coverage offered through the Marketplace. This differs from the premium tax credits, which an enrollee may apply to a plan of any tier.

The following table provides the scale for cost-sharing subsidies. These subsidies have the effect of increasing the actuarial value of the plan (the actuarially determined value of benefits covered by the plan rather than cost-sharing paid by the policyholder). This decreases a plan's out-of-pocket spending requirements.

Percent of FPL	Amount of Actuarial Value of the Plan after Subsidy
100% to 150%	94%
150% to 200%	87
200% to 250%	73
250% to 400%	No Subsidy

For example, an individual with household income between 100% and 150% of the FPL would be responsible, on average, for paying 6% of the covered expenses, rather than 30% of expenses that would otherwise be expected to be paid by individuals who purchase a silver plan.

Additionally, individuals who qualify for cost

sharing reductions have their annual maximum out-of-pocket costs reduced. In 2014, the out-of-pocket limits for plans offered in the Marketplace are $6,350 for an individual and $12,700 for a family. This limit does not count premiums, expenses for non-essential health benefits, and amounts owed for services provided outside a plans' approved provider network.

Based on rules promulgated by CMS, the ACA reduced maximum out-of-pocket costs in 2014 as shown in the following table.

	2014 Out-of-Pocket Maximum	
Percent of FPL	Individual	Family
100% to 200%	$2,250	$4,500
200% to 250%	5,200	10,400

Small Business Health Options Program and Small Business Tax Credit

Employer-sponsored group health plans are the primary source of health care coverage for Americans. Information from the U.S. Census Bureau indicates that in 2010, approximately 55% of the nation's population was covered through employer-sponsored insurance. However, the cost small firms pay for providing coverage to their employees has historically been high relative to costs paid by larger firms due to several factors, including previous underwriting practices, higher risks of providing coverage to smaller number of individuals, and fixed costs of using brokers and agents to administer health plans on behalf of employers.

The ACA requires that each state establish an exchange for the small group market, in addition to the individual market described previously in this paper. If the state chooses not to establish a small group market exchange, the federal government will create and operate the exchange. These small business health options program (SHOP) exchanges are intended to assist qualified businesses in purchasing health insurance for their employees by enabling them to obtain information and compare each qualified health plan sold on the exchange and to make these plans more affordable to small businesses by creating a larger pool of participating small businesses.

In 2014, 15 states and the District of Columbia had state operated SHOP exchanges. In 2015, federally facilitated SHOP exchanges will operate in all states, including Wisconsin, that do not operate their own SHOP exchanges. In that year, these exchanges will offer plans to qualifying businesses with 50 or fewer full-time equivalent (FTE) employees and, by January 1, 2016, plans on the SHOP exchanges will be available to firms with up to 100 FTE employees.

For plan years beginning in 2015, each state SHOP must make available to qualified employers the option of selecting a plan with an actuarial value of coverage, based on the four metal tier categories used for qualified health plans available in the individual market through the Marketplace (bronze, silver, gold, and platinum). In addition, each employee of an employer that selects a level of coverage may choose to enroll in a qualified health plan that offers coverage at that level, a provision that is referred to as "employee choice."

By rule, DHHS provided states the option, for 2015, to delay the implementation of the employee choice provision until 2016, if the state's Insurance Commissioner submits a written recommendation to the SHOP that explains why implementing employee choice would not be in the best interests of small employers and their employees and dependents, given the likelihood that it would cause insurers to price products and plans higher in 2015 due to the insurers' beliefs about adverse selection. As Wisconsin's Commissioner of Insurance did not submit such a recommendation, Wisconsin's SHOP program for 2015 will provide employee choices with respect to plans offered within the tier category selected by the employer.

Employers with 25 or fewer FTE employees with an average salary of $50,000 or less that pay at least 50% of the employees' premium costs that offers coverage to employees through SHOP Marketplace qualify for a small business health care tax credit. The credit is worth up to 50% of the employer's contribution for employee's premium costs, or 35% of the employer's contribution for tax-exempt employers.

Medical Assistance -- BadgerCare Plus Eligibility Changes

As passed, the ACA would have required all states' medical assistance (MA) programs to provide coverage to all adults under the age of 65 in families with household income up to 133% of the FPL, beginning January 1, 2014. For the purposes of determining MA eligibility under the ACA, household income equals modified adjusted gross income, plus a 5% income disregard, effectively setting the federal income standard at 138% of the FPL.

In Wisconsin, the current percentage of most MA benefit costs paid for by the federal government (the federal medical assistance percentage, or FMAP) is approximately 58%. The ACA requires CMS to provide enhanced federal matching funds for any "newly-eligible" group that did not qualify for full Medicaid coverage prior to December 1, 2009. For newly-eligible individuals, the ACA requires CMS to fund 100% of benefit costs in calendar years 2014 through 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and subsequent years.

The ACA requirement that states expand MA eligibility standards was one subject of the U.S. Supreme Court decision in *National Federation of Independent Business et al v. Sebelius*. The Court found the mandatory expansion of MA coverage unconstitutional. As a result, each state may decide whether to expand its MA program to the levels described in the ACA, and claim the enhanced federal matching funds for services provided to newly-eligible individuals.

MA income eligibility standards for adults vary widely among states. In Wisconsin, prior to the enactment of 2013 Wisconsin Act 20 (the 2013-15 biennial budget act), parents and caretaker relatives with household income under 200% of the FPL qualified for full MA coverage under the state's BadgerCare Plus program, while adults without dependent children were not eligible for MA coverage, unless they had enrolled in the BadgerCare Plus Core Plan for childless adults with income under 200% of the FPL, prior to September, 2009, when DHS ended new enrollment in that program.

The Legislature considered the issue of MA income eligibility standards for nondisabled, nonelderly adults as part of its 2013-15 biennial budget deliberations and established the income standard at 100% of the FPL, effective January 1, 2014. This had the effect of reducing the eligibility standard from 200% to 100% of the FPL for adults with dependent children, while providing eligibility for all adults without dependent children with income up to 100% of the FPL. Adults with income above 100% of the FPL and no access to other affordable coverage may purchase subsidized coverage through the Marketplace.

As the enhanced FMAP for newly-eligible populations is only available to states that increase their maximum income standard to 133% of the FPL, the state does not receive the enhanced federal funding available under the ACA. Instead, the cost of most services provided to adults enrolled in BadgerCare Plus are funded at the state's regular FMAP rate (currently, approximately 58% with federal funds and 42% with state funds).

In response to the difficulties experienced by individuals attempting to purchase subsidized pri-

vate coverage through the federal health insurance marketplace in the fall of 2013, the Legislature delayed the Medicaid eligibility changes from January 1, 2014, to April 1, 2014, by enacting 2013 Wisconsin Act 116. As a result, parents with incomes between 100% and 200% of the FPL did not lose Medicaid eligibility, and adults without dependent children with income below 100% of the FPL did not gain Medicaid eligibility, until April 1, 2014.

As of July 1, 2014, there were 119,090 adults without dependent children enrolled in BadgerCare Plus, compared with 13,923 childless adults that were enrolled in the BadgerCare Plus Core Plan in March, 2014 (the month prior to the eligibility change), an increase of 105,167. All of the adults without dependent children currently enrolled in BadgerCare Plus qualify for full MA benefits under the state's "standard plan," rather than the more limited coverage offered under the Core Plan.

DHS determined that 62,776 adults who had been enrolled in BadgerCare Plus in the previous month no longer met the new income standards for the program that took effect on April 1. Through a data sharing agreement with CMS, DHS determined that: (a) 18,801 of the adults (30%) selected a qualified health plan through the Marketplace; (b) 5,859 of the adults (9%) either re-applied and were enrolled in MA (4,867) or reapplied and were enrolled in MA and selected a qualified health plan through the Marketplace (992); and (c) 38,116 (61%) did not select a plan through the Marketplace or did not re-apply and enroll in MA. It is not known how many adults in the last group obtained health care coverage through other means, such as purchasing coverage not sold in the marketplace, or obtaining coverage through an employer.

Additional Resources

Additional information on the ACA and its implementation in Wisconsin is available through the following resources:

Federal Health Insurance Marketplace
www.healthcare.gov

Wisconsin Office of the Commissioner of Insurance (OCI)
www.oci.wi.gov/healthcare_reform.htm

Wisconsin Department of Health Services (DHS)
www.dhs.wisconsin.gov/health-care/index.htm

U.S. Department of Health and Human Services (DHHS)
www.hhs.gov/healthcare

DHHS Centers for Medicare and Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight
www.cms.gov/cciio/index.html

U.S. Internal Revenue Service (IRS)
www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions-Home

APPENDIX 1

Examples of Employer Shared Responsibility Payments

Example	Firm Size (FTE Employees)	Offered Coverage?	Number of FTE Employees that Received a Premium Tax Credit	Calculation of Payment (for the Year)	Amount for Year
1	100	No	0	As no FTE employee received the premium assistance tax credit, no payment.	$0
2	100	No	40	(100 FTE employees - 30 FTE employees) x ($2,000 per FTE employee)	$140,000
3	100	Yes	40 for 12 months each	($3,000 per FTE employee receiving tax credit) x 40 FTE employees that received premium tax credit	$120,000
4	100	Yes	60 for 12 months each	($3,000 per FTE employee receiving tax credit) x 60 FTE employees = $180,000 This exceeds the maximum for the employer [(100 FTE - 30 FTE employees x ($2,000 per FTE employee) = $140,000], so the employer would pay the maximum.	$140,000
5	100	Yes	40 for six months each	($3,000 per FTE employee/12 months) x six months x 40 FTE employees that received the tax credit for each of the six months	$60,000
6	45	No	25	As the employer has fewer than 50 FTE employees, there is no payment.	$0

APPENDIX 2

Selected Information Regarding Plan Selections in Wisconsin's Marketplace During the Open Enrollment Period (October 1, 2013 to March 31, 2014)

Total Number of Individuals Enrolled in a Qualified, Non-Catastrophic Health Plans	139,815
Number Who Qualified for Financial Assistance	126,991
Percent Who Qualified for Financial Assistance	91%

Enrollment by Age and Gender

	Number	Percent
Less than 18	6,311	4.5%
18 through 25	12,188	8.7
26 through 34	23,554	16.8
35 through 44	21,620	15.5
45 through 54	30,771	22.0
55 through 64	45,199	32.3
65 and Older	172	0.1
Total	139,815	100.0%
Female	77,241	55.2%
Male	62,548	44.7
Information Unavailable	26	<0.1
Total	139,815	100.0%

Enrollment by Plan Metal Level

Bronze	28,027	20.0%
Silver	100,588	71.8
Gold	8,990	6.4
Platinum	1,176	0.8
Catastrophic Plans	1,398	1.0
Total	140,179	100.0%

- Enrollment by plan exceeds the total enrollment because some individuals enrolled in more than one plan. For these purposes, enrollment represents the number of individuals who were determined to be eligible to enroll in the Marketplace, and who selected a plan, rather than the number of individuals who made a premium payment for a plan they selected.

APPENDIX 3

Total Marketplace Eligibility Determinations and Marketplace Plan Selections By Marketplace Type and State

State	Total Determinations	Eligible for Financial Assistance Number	Eligible for Financial Assistance Percent	Number of Persons Who Selected a Marketplace Plan	Medical Assistance: Expanded MA Eligibility for Adults to 133% of the FPL in 2014	Medical Assistance: Number of Persons Determined or Assessed to be Eligible for MA or CHIP
States with State-Based Marketplaces						
California	1,886,867	1,458,433	77.3%	1,405,102	Yes	1,700,000
Colorado	205,910	88,208	42.8	125,402	Yes	181,983
Connecticut	113,390	80,354	70.9	79,192	Yes	138,908
District of Columbia	15,437	4,033	26.1	10,714	Yes	19,464
Hawaii	15,694	4,549	29.0	8,592	Yes	N.A.
Kentucky	201,593	91,092	45.2	82,747	Yes	357,990
Maryland	99,298	84,015	84.6	67,757	Yes	163,602
Massachusetts	31,695	N.A.	N.A.	31,695	Yes	N.A.
Minnesota	101,645	36,217	35.6	48,495	Yes	144,481
Nevada	134,942	89,683	66.5	45,390	Yes	182,946
New York	707,638	369,380	52.2	370,451	Yes	646,018
Oregon	124,840	99,902	80.0	68,308	Yes	207,329
Rhode Island	43,295	32,471	75.0	28,485	Yes	70,243
Vermont	95,203	28,797	30.2	38,048	Yes	41,704
Washington	240,880	151,441	62.9	163,207	Yes	909,752
Subtotal	4,018,327	2,618,575	65.2%	2,573,585	15 Yes	4,764,420
States with Marketplaces That Are Supported By, Or Fully Operated By DHHS						
Alabama	195,779	105,059	53.7%	97,870	No	22,564
Alaska	21,915	14,898	68.0	12,890	No	4,172
Arizona	216,951	144,376	66.5	120,071	Yes	101,282
Arkansas	80,709	53,958	66.9	43,446	Yes	73,681
Delaware	24,721	16,170	65.4	14,087	Yes	11,200
Florida	1,603,575	1,114,877	69.5	983,775	No	180,479
Georgia	572,025	343,925	60.1	316,543	No	91,914
Idaho	107,849	83,662	77.6	76,061	No	10,709
Illinois	369,696	242,255	65.5	217,492	Yes	181,070
Indiana	229,815	155,961	67.9	132,423	Pending	94,495
Iowa	57,184	37,328	65.3	29,163	Yes	36,891
Kansas	99,380	59,601	60.0	57,013	No	13,961
Louisiana	184,041	113,337	61.6	101,778	No	14,359
Maine	68,541	48,531	70.8	44,258	No	7,103
Michigan	467,878	297,742	63.6	272,539	Yes	67,217

State	Total Determinations	Eligible for Financial Assistance Number	Eligible for Financial Assistance Percent	Number of Persons Who Selected a Marketplace Plan	Medical Assistance: Expanded MA Eligibility for Adults to 133% of the FPL in 2014	Medical Assistance: Number of Persons Determined or Assessed to be Eligible for MA or CHIP
Mississippi	117,518	72,219	61.5%	61,494	No	13,779
Missouri	268,764	166,440	61.9	152,335	No	45,513
Montana	55,675	39,572	71.1	36,584	No	4,638
Nebraska	74,606	50,382	67.5	42,975	No	9,879
New Hampshire	64,901	39,818	61.4	40,262	Yes	7,235
New Jersey	301,965	193,286	64.0	161,775	Yes	179,872
New Mexico	58,628	39,543	67.4	32,062	Yes	30,147
North Carolina	581,173	396,212	68.2	357,584	No	73,898
North Dakota	16,627	11,974	72.0	10,597	Yes	6,843
Ohio	285,967	185,780	65.0	154,668	Yes	156,899
Oklahoma	127,915	76,301	59.6	69,221	No	17,374
Pennsylvania	549,205	332,915	60.6	318,077	Pending	42,335
South Carolina	213,974	134,969	63.1	118,324	No	28,359
South Dakota	24,147	16,243	67.3	13,104	No	3,850
Tennessee	305,628	169,470	55.4	151,352	No	83,591
Texas	1,371,157	835,519	60.9	733,757	No	141,494
Utah	130,945	97,621	74.6	84,601	Pending	50,268
Virginia	392,340	231,534	59.0	216,356	No	48,660
West Virginia	36,749	24,634	67.0	19,856	Yes	21,019
Wisconsin	230,516	168,721	73.2	139,815	Partial	81,274
Wyoming	20,806	14,629	70.3	11,970	No	2,216
Subtotal	9,529,265	6,129,462	64.3%	5,446,178	12 Yes 1 Partial 20 No 3 Pending	1,960,240
All States and DC	13,547,592	8,748,037	64.6%	8,019,763	27 Yes 1 Partial 20 No 3 Pending	6,724,660

Sources: Office of the Assistant Secretary for Planning and Evaluation, as it relates to Marketplace Enrollment (May 1, 2014).

Kaiser Family Foundation, as it relates to the status of state's MA eligibility expansion status.

APPENDIX 4

Examples of Monthly Required Premium Contributions, By Family Size*
Plan Year 2014

Family	Annual Family Income Based on Percentage of FPL						
Size	100%	133%	150%	200%	250%	300%	400%
One	$11,670	$15,521	$17,505	$23,340	$29,175	$35,010	$46,680
Two	15,730	20,921	23,595	31,460	39,325	47,190	62,920
Three	19,790	26,321	29,685	39,580	49,475	59,370	79,160
Four	23,850	31,721	35,775	47,700	59,625	71,550	95,400
Five	27,910	37,120	41,865	55,820	69,775	83,730	111,640
Six	31,970	42,520	47,955	63,940	79,925	95,910	127,880

Family	Monthly Required Premium Contribution, by Family Size						
Size	100%	133%	150%	200%	250%	300%	400%
One	$19	$26	$58	$123	$196	$277	$370
Two	26	35	79	165	264	374	498
Three	33	44	99	208	332	470	627
Four	40	53	119	250	400	566	755
Five	47	62	140	293	468	663	884
Six	53	71	160	336	536	759	1,012

*Assumes family purchases second-lowest cost silver plan available. Children under age 19 in families with income up to 300% of the FPL are eligible for Medicaid coverage.